IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF UTAH

CENTRAL DIVISION

NAVAJO NATION, a federally recognized Indian tribe, **LORENA ATENE, TOMMY ROCK, HARRISON (HUTCHINS) HUDGINS, WILFRED JONES**, **ELSIE BILLIE**, and **HERMAN FARLEY**,

Plaintiffs,

vs.

SAN JUAN COUNTY, a Utah governmental sub-division; **BRUCE ADAMS**, San Juan County Commissioner / Commission Chair; **PHIL LYMAN**, San Juan County Commissioner; **KENNETH MARYBOY**, San Juan County Commissioner; and **NORMAN L. JOHNSON**, San Juan County Clerk / Auditor,

Defendants.

Case No. 2:12-cv-00039-RS

Expert Witness Report

Lillian Tom-Orme, Ph.D., MPH, RN, FAAN

I. BACKGROUND

I am Lillian Tom-Orme. I was born and raised on the Navajo reservation in New Mexico and Dine' is my first language. I am a research assistant professor in the School of Medicine at the University of Utah. My degrees are from the University of Utah: Bachelor of Science in nursing (1977), Masters in Nursing (1981), Doctorate in Transcultural Nursing (1998), and a Masters in Public Health (1996). I have been a nurse since 1973. For about 14 years I worked in

public health at the Utah Department of Health in diabetes, tuberculosis, and refugee health. My work involved working with populations highly impacted by diabetes including the Navajo and Ute people, those affected by the new epidemic of tuberculosis including underserved populations, and refugees coming from foreign countries. I have been at the University of Utah since 1996 as a public health researcher focused on American Indian public health and health disparity issues.

My curriculum vitae is attached as Exhibit A.

I have been hired by Maynes, Bradford, Shipps, and Sheftel, LLP to study the relationship of the Navajo people and San Juan County, UT in health matters from the 1950's to today. I am compensated at the rate of $80 per hour. Specifically, I will attempt to answer the following question: **What are the historical and current health conditions and health services experienced by Navajo people of San Juan County, Utah?**

II. METHODOLOGY

Data and information were gathered from a number of sources including interviews (in-person and telephone), documents and reports from the State of Utah and Navajo Nation, newspaper accounts (San Juan Record, Panorama, Salt Lake Tribune, Navajo Times, IFree Press, Deseret News), scientific articles, books, and census data.

Indian communities in San Juan County, Utah, are described as follows:

Navajo Mountain, known as *Naatsis'aan* in Dine' is considered the most remote community on the Navajo reservation (Navajo Times, 10/17/13), and is about a 3-hour drive from Monument Valley. In October 2013, it was estimated that only 30%of residents has electricity and running water. Access by road has always been an issue until about 2008, the 15 mile stretch was paved to make travel easier. Navajo people who live here escaped the Kit Carson round-up in the 1860's when they were marched to imprisonment in Ft. Sumner, NM.

The people here are a hardy bunch as they have fought for their survival in this remote area; a court battle for a school was one battle won in 1973 (10/17/13). Health care was another difficult matter since the days of Father Liebler (1969) and more recently was delivered by Dr. Benedict who flew in to provide medical services (Deseret News 1989). Today, they are proud of the R. Dean Benedict Health Center, which is part of the new Utah Navajo Health System (UNHS) that replaced the old Navajo Utah Navajo Council (UNDC) program. For a number of years, Dr. Benedict was the sole doctor providing medical serves in the Utah Strip by flying weekly to this remote area. A former Air Force flight surgeon, he gave 10 years (1979-89) to the Navajo people of Utah who affectionately called him *Tl'izisani'* (FamilySearch, 2014.) A band of Southern Paiutes known as San Juan Paiutes living near the Colorado River in the area of what's known as Navajo Mountain (but Paiute Mountain by the Paiutes), speak of the time they helped Navajos hide on their traditional land during Kit Carson's roundup campaign for the Long Walk (personal communication with Southern Paiute Ute President Mae Preston, 2014; Navajo Times, 10/31/13). Eventually, many Navajo families settled here or intermarried with the Southern Paiutes in this extremely isolated area.

Mexican Water straddles the Arizona and Utah state lines in the middle of the red sandy desert. The community works with both state governments and county governments. Governor Gary Herbert has visited them but never the Arizona governor. Arizona will declare a state of emergency during droughts or harsh winters, which is helpful but never the state of Utah. Some people complain that their homes are falling apart and need help with repairs but at the time of an interview with the Navajo Times, neither Arizona nor Utah was listening. (Navajo Times, 9/12/13). Health Care is received from either Montezuma Creek, UT but more people were using the Red Mesa, AZ Four Corners Regional Health Center (personal communication, Martha

Saggboy, 2015).

Oljato is another chapter community with several jurisdictions running through it; 2 Arizona counties and one Utah county, and 2 San Juan County, UT voting districts (Navajo Times, 11/27/13). Many people living adjacent to the world-known Monument Valley Tribal Park live without electricity as power lines are not allowed. Vendor stands have been built for locals to sell jewelry to tourists and a welcome center was built on the Utah side using the Utah Trust Fund. At one time, there were 95 uranium mines located here and many miners and family members developed health problems and died. Tailings from the mines remain and have not been removed in some places. There are 2 court-ordered schools, a high school built in the late 1970s and an elementary school that opened in 2011. Both were constructed as a result of federal civil rights law suits. Today, Oljato has the new Monument Valley Health Center located near the high school and visitor's center. Formerly, medical care was received from the Monument Valley Adventist Hospital which closed down in the mid-90's.

Aneth, UT has had oil since 1933 and 37.5% of the royalties were to be held in trust for people of this area. The question that remains unanswered is who ought to hold these funds in trust-the state of Utah, the Navajo Nation, the local chapter, or a local organization? This debate is not soon to get an answer (Navajo Times, 11/3/11). Aneth chapter which includes Montezuma Creek community has 4 schools, a health center, a fairly new professional plaza, a river (San Juan River) running through it and about 700 oil wells all around (Navajo Times, 9/27/12). Aneth and Montezuma Creek are located in the southeastern portion of San Juan County and on the Navajo reservation. Montezuma Creek has been home to the UNDC clinic for many years before it became the Utah Navajo Health System's largest health center with a population of about 2,500.

III. HEALTH CONDITIONS AND SERVICES OF THE NAVAJO PEOPLE IN SAN JUANC COUNTY, UTAH

The Navajo people or Dine' have lived in their present homeland of what are now parts of the states of New Mexico, Arizona, and Utah prior to the Long Walk of 1865. Their treaty with the United States government was signed in 1868 (Underhill, 1953; Navajo Times, 10/31/13). Mr. Robert Billie Whitehorse, a long-term Navajo leader from the Aneth area, who was born at home prior to 1950, recalled how there was no organized health care in the Montezuma Creek and Aneth areas during this time as "many people were born at home." As a 12-year old, he remembers how his neighbors and relatives from Cahone Mesa caught a ride to the Bluff Mission (St. Christopher's) for health care.

"When my sister was sick we took her there [St. Christopher's]. A lady at the mission gave shots. The other closest place was Shiprock [New Mexico] but there were no developed roads back then. TB was a problem; my mother had it. She went to Shiprock and they shipped her to Boulder, CO. The Mission clinic phased out in the mid-1970's; a small clinic started 1-2 days a week in Montezuma Creek. They (mission) helped Navajos a lot with the clinic, clothes, and food. "

"When I was 6 or 7 years old, I remember the white rancher coming onto the reservation on horseback, they carried guns, and when they came to home they always asked for the man of the house. They confiscated Navajo sheep, hauled them to Monticello, and asked for Navajo to pay to get their sheep back. Navajo people were afraid of them and they had no other reason to go to Blanding or Monticello. Navajo people didn't know the laws or their rights. They were not allowed to drink or couldn't vote. They always said don't bother white man, leave them alone, they will shoot you. So Navajo people feared *Bilagaana*." Personal communication, Robert Billie Whitehorse, 2014.

"I didn't go to school until I was 14 because I lived in [remote] Cahone Mesa. I enrolled at Aneth; it's [school] now closed. Later I went to Shiprock and then Intermountain School [in Brigham City, UT]. That's how we learned about our rights. That's how we started talking about our own schools and clinics. I learned about Navajo tribal government from Bill Hatalhi; he rode his horse to Window Rock as a councilman." Personal communication, Robert Billie Whitehorse, 2014.

The Seventh Day Adventists opened a small nurse-operated clinic in 1950, by Mrs. Walters, wife of a church minister in Monument Valley. Local Navajo people assisted with the construction of the clinic. The Mineral County Independent (1954) reported that the life expectancy of the Navajo at that time was 30 years and that tuberculosis and malnutrition were major health problems. On a monthly basis, Seventh Day Adventist doctors from other southwestern towns came to hold medical clinics and many Navajos came to be seen. The closest hospital at this time was located in Tuba City, AZ, 100 miles away. Any emergency cases were transported there. (Mineral County Independent, October 1954). The clinic treated between 40-60 patients daily. (Pacific Union Recorder 1959).

In 1952, the Bureau of Indian Affairs (BIA) of the United States government having the responsibility for Indian health care x-rayed about 20,000 Navajo adults and discovered they had immediate need for 500 beds for active tuberculosis (TB) cases. As a result, the BIA, the Navajo Tribe and Cornell University contracted for sanatoria beds in California, Arizona, New Mexico, Oklahoma, and an additional six locations (Adair, Deuschle & Barnett, 1988; Bahl, 1984).

In 1955 the responsibility for the provision of medical care to America Indians was transferred from the Bureau of Indian Affairs to the Public Health Service of the United States Department of Health, Education, and Welfare (Adair, Deuschle & Barnett (1988). Between

1956 and 1960, a primary health care unit was initiated in Many Farms, AZ called the Navajo-Cornell Field Health Research Project. Cornell University initially got involved in a hepatitis outbreak in the Tuba City boarding school and decided to stay as researchers as they found third world conditions of poverty accompanied by tuberculosis and dysentery on the Navajo reservation. Tuberculosis treatment requires isolation to prevent the spread through respiratory droplets, dailymedication, and good nutrition. For these reasons, patients required hospitalization. Isolation was not feasible because Navajos lived in one-room *hogans* with little air circulation and in close quarters with the extended family. Dysentery (diarrhea), respiratory infections, malnutrition, and other infections were major reasons for infant death at this period in time. Poor sanitation and housing contributed to many of these illnesses and conditions.

Eventually, Navajo infant mortality decreased from 85 per 1000 live births in 1954-56 to a rate of 13.3 per 1000 live births in 1980. The 1953-55 TB rate of 896.1 per 100,000 population decreased to 10.3 per 100,000 population in 1980 (Adair, Deuschle & Barnett, 1988). While there were six hospitals on the Navajo reservation in Arizona and New Mexico, Navajo people in Utah did not have access to a hospital within at least 70 miles (to Shiprock, NM from Aneth, UT and 100 miles to Tuba City from Monument Valley, UT) during these early years. Monument Valley is in the western portion of San Juan County, UT. In 1958, Dr. Lloyd Mason, Seventh Day Adventist doctor came to the area to open the Monument Valley Adventist Hospital (MVAH) as he saw a tremendous local need for medical care. A dental clinic was added in 1972. Both dental and medical students from Loma Linda University came to MVAH to provide care and learn about rural health care. Due to the great need for obstetrical services, a birthing center was opened to serve this need. By the 1990's the MVAH was serving a population of 4000 Navajos. By this time, there was an Indian Health Service (IHS) out-patient clinic in Kayenta,

AZ (30 miles away), across the state line, however, the only other IHS hospital was still 100 miles away in Tuba City, AZ. (Deseret News, 1994). Due to financial issues and related regulations and codes, unfortunately, the MVAH closed its doors in 1995.

A report by the Utah Hospital financial and utilization profile inpatient discharges for calendar year 1993 showed that the 20-bed MVAH served 419 patients: 27% for medical reasons; 24% for pediatric medical or surgery; 19% for obstetrics; 13% for newborn; and the remainder for other surgery, psychiatric, and rehabilitation conditions. (Utah Department of Health,1993).

A total of 258 (62%) were female, 159 (38%) were male, and 2 were not reported. In addition, type of admission was distributed as follows: 278 (66%) emergency, 54 (13%) urgent, 18 (4%) elective, 38 (9%) newborn, 30 (7%) not reported. For 228 (54.5%), the primary payer was either Medicaid or other government entities, most likely the Indian Health Service and Medicare.

The Health of Navajo people in the 1950's in the Montezuma Creek and Bluff areas is described by Father Baxter Liebler (1962, 1969) who settled in Bluff, UT to begin an Episcopal Church at St. Christopher Mission in 1943. In the book, *Boil My Heart for Me* (1969) he spoke of Navajo people of all ages coming from various distances to seek medical care for illnesses including tuberculosis, trachoma, burns, injuries, and childbirth. There was no automated travel, but Navajo people traveled on foot, by horseback, or by wagon and there was no medical staff at the mission but people came anyway to seek care. Father Liebler and his staff had a vehicle and knew about health care facilities in as far away as Ft. Defiance, AZ where there was a tuberculosis sanatorium; Shiprock, NM had an Indian Health Service hospital, and Cortez, CO had a private hospital. These facilities today are located 115, 70, and 53 miles from Bluff, respectively.

But before modern roads some of which were described as wagon train travel, Liebler (1969) transported sick people to Ft Defiance if they appeared to have signs of TB such as coughing, weight loss, or chest pain. Due to his association with doctors in Ft Defiance, he once received a visit from a Ft Defiance doctor to see Navajo patients. Many Navajo people and some non-Indians from Blanding came to see the visiting doctor as word had spread. The number of people seen was not mentioned in Liebler's account, however, they kept the doctor busy into the evening. Eventually, word spread to Salt Lake City about the dire need for health care and St. Christopher's Mission subsequently received visits from the Utah Department of Health in Salt Lake City, UT. As Liebler saw more and more Navajo people seeking help with health care, he opened what he called a "nosocome" because he thought the facility was neither a clinic nor a hospital, although some Navajo people stayed over night or remained while recuperating. Over time estimates of 500 deliveries were reported to have taken place in this setting. (Phone interview Steve April 2015).

In 1954, the top five leading causes of death (rates per 100,000 population) among the general Navajo population as compared to the US general population were estimated as follows:

1. Pneumonia (123.5 vs. 23.7), five times the national rate;
2. Gastrointestinal (110.2 vs. 5.3), twenty one times the national rate;
3. Certain diseases of early infancy (102.2 vs. 39.4), two and one-half the national rate;
4. Accidents (81 vs. 56.9) and 1.4 times the national rate;
5. Tuberculosis (53.0 vs. 10.5), five times the national rate.

These figures are from 1954 estimates by the US Public Health Service as reported by Adair, Deuschle & McDermott (1957). Thus, pneumonia, gastrointestinal diseases, and tuberculosis rates were 5 times that of the general US population. The infant mortality rates were

estimated to be 108.6 per 1000 live births as compared to the US rate of 26.6 per 1000 live births or 4 times greater than the national rate.(Adair, Dueschle & McDermott, 1957).

Environmental and social conditions during this time were such that Navajo people lived in extremely rural areas in extended family groups, in crowded *hogans* (homes made from mud and logs), long distances to the few available medical facilities in larger towns, had horses or wagons as means of transportation, were not informed about infectious diseases or how to prevent dehydration, and the majority were illiterate due to the lack of schools. At least 40 percent of births were not recorded as they took place in remote homes; the average life expectancy was 30-40 years; and Navajo health status and living conditions were comparable to underdeveloped countries (Adair, Dueschle &McDermott, 1957).

In summary, the 1950's saw the Utah Navajo with very little health or medical care but two religious charity organizations started a clinic (St. Christopher Mission) and a hospital (Monument Valley Adventist Hospital). New Mexico and Arizona had federal Indian Health service hospitals, which were located too far for people to travel on horseback or wagon. Tuberculosis and infectious diseases were rampant and exceeded the national U.S rates by at least 4-5 times. Navajo people did not mix with the white settlers in Blanding and north; in fact, they were afraid of them.

During the 1960s, infectious and communicable diseases remained a problem among the Navajo population throughout the reservation, including San Juan County, Utah. Adair, Dueschle & McDermott (1957) state that "more than any other major disease, tuberculosis is the expression of the socioeconomic conditions in a community." Poor hygiene and housing and poverty conditions remained a problem contributing to the persistence of infectious diseases. It was estimated that there were 2000 or more cases of tuberculosis throughout the Navajo

reservation at this time. A sanatorium for tuberculosis treatment was opened in Ft Defiance, AZ on the Navajo reservation close to a 200 mile trip from San Juan County, UT. Other sanatoria were located about 250 miles (Albuquerque) and 350 miles (Salt Lake City). Due to the roles played by poor hygiene, sanitation, housing, nutrition in tuberculosis control, various health agencies were required to begin to tackle the problem on the Navajo reservation.

Finally, plans to eradicate tuberculosis in the Utah Strip (in San Juan County, UT) of the Navajo reservation were initiated at the 1960 Utah Governor's Conference. A grant from the US Public Health Service was received in December 1960 for $96,950 to fight TB. The Utah Department of Health and Utah Tuberculosis and Health Association were the two primary agencies that led the charge. The Christmas Seal Society joined later. A Navajo interpreter, Sam Capitan from San Juan County, was hired to help with health education and language translation (San Juan Record, 3/30/78). San Juan County joined the effort to control tuberculosis. By the mid-1960s a larger group joined the TB elimination campaign that included Dr. CD Goon from San Juan Hospital in Monticello, San Juan County ; the Indian Health Service; 2 San Juan County Commissioners, Annie Wauneka (Navajo educator and advocate) from the Navajo Tribe; a San Juan County public health nurse; the Utah TB Association; the San Juan County welfare director; a Dr. Findlay from St. Christopher Mission; Dr. Davis Lodge from Monument Valley Adventist Hospital; a Blanding physician; M. Jensen from the Mormon Church Indian Placement Program; and Navajo interpreters and drivers. Mobile x-rays machines were brought in from Salt Lake City. (San Juan Record, 11/24/64). This was the first documentation of San Juan County's involvement with a large group of representatives from diverse agencies interested in tackling the TB problem among the Navajo of San Juan County, UT.

One week in June 7-June 11, 1965, 775 patients were seen in 5 clinics in Navajo Mountain, Monument Valley, Bluff, Aneth, and Blanding. Patients included former TB patients needing follow up, contacts of TB patients, current patients, family members, and curious onlookers for screening. Seventy-two were considered suspects of having active TB (9%). Six were referred immediately to a hospital for treatment. Between 1965 to 1970, 2 clinics were held each year and later 3 clinics per year; and a total of 4692 patient visits were made (San Juan Record, 4/6/78).

Other major problems were the high infant mortality due to dysentery and dehydration as well as malnutrition. Again these conditions were related to hygiene, sanitation, nutrition, and housing. Lack of transportation and poor roads contributed to delays in treatment. Additional problems included respiratory illness, conjunctivitis, trachoma, chronic ear infections and gallbladder disease (Adair, Deuschle & McDermott, 1957).

Malnutrition marked by protein deficiency was often seen among children after the first year of birth whereas in developing countries malnutrition was observed within the first year of life (Kane & Kane 1972). Chronic malnourishment contributes to various infections and ill health. Although the majority of the Navajo population remained in outlying remote areas, some families began to move into towns like Shiprock, NM in the Northern Agency. In San Juan County, UT, they started moving into towns including Montezuma Creek, Bluff, Mexican Hat, and Monument Valley.

Bruce Shumway who was working as director of the "welfare" program, later known as Social Services, remembered how there were no paved roads in the early 1960's and "many [Navajo] kids were not in school at that time. The state roads were serviced but Navajo homes were often located in remote areas not accessible by paved roads.

"We helped many kids get into school here in Blanding and Monticello with foster families. If we could get scholarship and financial assistance for them we sent them to BYU, Weber State or Utah State. We also worked with the [Navajo] tribe in ways for students to improve their lives. We added craft training- like bead work, silver work, weaving, picture frame making. The state closed this down because we were so successful that we were told that we were competing with private industry." (Personal communication, Bruce Shumway, 2014)

On January 6, 1960, San Juan Hospital opened its doors in Monticello (San Juan Record, March 29, 2015). Between 1960 and 2015, 31 doctors and 18 administrators have served the San Juan Hospital in Monticello, San Juan County.

In summary, the 1960's were a time of organized efforts within San Juan County by many organizations including the Navajo Tribe, the Indian Health Service, Utah Department of Health, and even San Juan County to plan for tuberculosis elimination.

In the early 1970's infectious disease rates remained higher than national averages. New cases of tuberculosis was almost 8 times greater as more testing took place; streptococcus infections were 34 times greater, gonorrhea cases were 10 times greater, syphilis cases were 6 times greater (Kane & Kane, 1972). Southeastern Utah Health District contracted with San Juan County to oversee TB services; the 1973 contract was signed by Dr. Ray Cowley (SEUHD medical director) and (R. Dale Holmes, San Juan County Commissioner Chair). The contract, in part, read:"The District will ensure the coordination of local resources in San Juan County in operating Tuberculosis out-patient clinics; provide educational materials and guidelines to promote public support and understanding of all aspects of a Comprehensive Tuberculosis Treatment & Control Program; work through and wit local resources and with the Indian leaders in securing support for attendance at clinics and skin testing programs. The District will further

ensure, under the direction of the District Health Officer, Director of the Navajo Development Council, Public Health Nurses and District staff, that individuals on anti-tuberculosis drugs, new reactors, cases, contacts, suspects, and associates of reactors, are visited where indicated, scheduled for Tuberculosis Clinics, and that their attendance" (San Juan County Commissioners, 1973).

In addition to the lingering infectious diseases, newer health problems were on the rise including automobile accidents, alcoholism, mental health problems and family planning problems (Kane & Kane, 1972). By this time accidents had become the leading cause of death among Navajo adults. Although rates of alcoholism are hard to come by, estimates varied between 4.5% to 17.4% in hospital discharge records among certain age groups. In the southwest the prevalence of "Drinkers" was estimated at 73-86% among men and 20-68% among women. Specifically, among Navajos within the Shiprock Service Unit, that included San Juan County, UT, estimates for public intoxication were close to 9 percent in one nearby border town (Kane & Kane, 1972). Alcoholism had become such a pervasive public and mental health problem as it contributed to family breakup, neglected children, unemployment, feelings of depression, etc. and contributed to unnecessary death and disability. In addition to alcoholism as a reason for vehicular accidents, non-use of seat belts and riding in open pickup beds were other public health problems where health and prevention education were needed.

By the late 1970s, Marion Hazelton, Director of Southeastern Utah Health District (including the counties of Grand, Emory, San Juan) reported that it had taken 15 years [of concerted effort] to reduce the TB rate among the Navajo of San Juan County and it had taken the rest of the state 65 years to reduce TB rates. Navajo childhood infection rate was reduced to

less than 1% from 25%; teen infection rate was reduced to 6% and adult infection rates ranged from 36 to 70%.

In the 1970's, Navajo from San Juan County took ill family members for Indian Health Service care in Shiprock, NM; Tuba City AZ; and Kayenta, AZ; and for private care in Farmington, NM and Cortez, CO even though distances were great. By this time, many families owned vehicles and the roads were paved in San Juan County.

In summary, infectious disease rates remained high but the disease pattern is beginning to shift more towards injuries and chronic health problems including mental health and alcoholism. Transportation is beginning to improve as more people have vehicles and are beginning to travel to Indian Health Service facilities for care even though the distances are still great. State roads are paved but roads to Navajo homes remain unimproved. Southeastern Utah Health District, of which San Juan County is included, has been involved in TB control efforts and progress is being made with rates of active disease decreasing.

In the 1980s, Jill Bayles, a long term [Caucasian] nurse leader in San Juan County, recalled how there was no home-based nursing provision when she started out to work as county nurse. Instead she was assigned to teach 5th grade health classes in Mexican Hat and Bluff schools. "Community nursing came in later in the early 1980's, it came out of Salt Lake for about 10 years, so nurses could make home visits then. Medicare reimbursement helped to cover this work. Roads were better at this time and Native Americans could move around better. They had strong traditional values so it was a challenge to work with them with their beliefs. [Many of them still had to travel long distances] to Kayenta, Farmington, or Cortez but didn't come to Monticello for care." [Ms. Bayles worked in the 1980s in public health and the nursing home and stopped nursing in 2000.] (Jill Bayles, personal communication, 2014).

Austin Lyman worked in social services, aging, and mental health for 25 years with Navajo clients in the southern portion of the county until 1997. He remembers providing for the "many needs Navajo clients had including food, money, medical support, children's special needs—a whole range of things. We brought in people from the State [Health Department] and Primary Children hospital to work with kids with special needs. For medical services they had Indian Health Services and were referred to Shiprock. Some came here [Blanding] for medical care. Sometimes they went to Monticello but were referred to Shiprock. Navajo licensed social workers came on after 1975." (Austin Lyman, personal communication, 2014).

Due to the amount of need for mental health and aging services, a day treatment center was opened in Montezuma Creek and Blanding.

"Roselyn Maryboy [Navajo] recently retired from the state; she is now with [Utah Navajo Health Service] UNHS, a good worker. We had program where we went out to the reservation for different services. All these were state funded programs." (Austin Lyman, personal communication, 2014).

Mr. Austin took pride in the work he did with the Navajo clients. "We referred to Monument Valley Hospital and they referred to us. Roads were paved all the way to Navajo Mountain. 95% of our Aging Waiver program was Navajo. I liked that program; it was more pleasure than work. When I started, Navajos didn't have service; we expanded the programs to Navajo Mountain."

In the 1980's, Monument Valley Adventist Hospital (MVAH) remained in operation as a small remote mission hospital. They were challenged by the changing reimbursement system in the health care industry, the limited payment options of their clientele, and the challenges in patient care coordination with the nearby Indian Health Service facilities. Dr. Nicola Ashton

recalled how as medical director, he was often frustrated by the coordination of patients with the nearby IHS clinic in Kayenta, yet MVAH had to deliver care Navajo patients and others who came to their door. (Nicola Ashton, personal communication, 2014).

Diabetes was beginning to appear as one of the leading causes of morbidity among the Navajo and local health facilities including MVAH and the Utah Navajo Development Clinic had to prepare for this emerging epidemic. MVAH purchased a new blood chemistry machine with the capacity to perform 15 different rests in about 10-15 minutes. Weber State University offered a new rural program including x-ray technicians and to upgrade nursing skills using self-teaching modules. In addition, 2 German students spent time for a clinical rotation and 2 Loma Linda dentists conducted much needed oral surgery on some patients. They also conducted dental checks on students in Aneth, Bluff, Montezuma Creek, and Mexican Hat schools. Thus, MVAH reached beyond its local service area of Monument Valley but extended its dental service to the eastern part of the Utah Strip in San Juan County. (San Juan Record).

The San Juan County Hospital received a two-year accreditation by the Joint Commission Accreditation Hospital on Healthcare Organizations (JCAHO), under the administration of Arlow Freestone in January 1980. The hospital has had a history of constant change in administrators and challenges in it financial management.

In March 1980, Intermountain Health Care (IHC) had conducted a study and submitted a thorough report on its findings that included 13 recommendations to the Hospital Board (San Juan Record, 3/20/80). Study recommendations were made based on the hospital board's request in consideration of the state of technology and the County's shifting and changing population. Of the 13 recommendations made, four that were relevant to the larger county population were stated as follows:

1. Include a broader representation of people within its service area [i.e. San Juan County],

2. Expand board's committee structure to include members not on the governing board,

3. Organize planning for future development of health care in the service area, and

4. Develop marketing plan to promote the health care system [throughout the county].

In June 1980, the hospital board had voted twice but remained undecided as to which one of three companies to select to manage San Juan Hospital. (San Juan Record, Vol. 63, No. 22, 6/19/80. County Commissioners signed a management contract for the San Juan County Health District including the hospital, nursing home, Blanding Clinic, County Emergency Medical Technician (EMT) program, and ambulance service. Wayne Ross, formerly of San Pete Valley Hospital, was appointed as IHC director of San Juan County facilities. He would focus on unifying health services throughout San Juan County. A Freestone was released by IHC by 9/1981. After protests by local citizens about the firing of Mr. Freestone and other meetings of the hospital board and county commissioners, by December 1981, the contract with IHC was eliminated and management was transferred back to the County. Rayburn Jack (local nursing home administrator) was appointed acting director. Citizens called for an investigation of the hospital management under IHC and later in the year protested the new health board. Meetings seemed to be divided between north county (Monticello) and south county (Blanding) and the Navajo reservation.

The Blanding Clinic opened under the County Health District management to serve Blanding citizens. This also made it easier for Navajo patients from the reservation to access this service as paying patients rather than traveling the distance to Shiprock, NM. Dr. James Redd, local physician, completed a two-year training as a National Health Service Corp physician only

to leave for further training in Phoenix. Upon completion of that training, he returned to Blanding to practice with Dr. DL Gibbons. Dr. Redd's family practice had a large Navajo clientele.

Eight persons including two from the southern portion of the county were appointed to serve on the San Juan County Health Services Board; two of them were from the reservation portion of the county: Tully Lameman, (Navajo), UNDC Executive Director and Whitehorse High School Principal, Mitch Kaulauli.

Changes in personnel also happened at the Health District level. Long time health director, Marion Hazleton resigned from Southeastern District Health Department and Bob Furlow took over as the new Health Officer. Hazelton had been instrumental in the collaboration with other health entities on the tuberculosis elimination campaign. San Juan Center of Higher Education, a local community college, began making plans for a more permanent college, possibly an extension of College of Eastern Utah, located in Price, UT. Meetings were held with Weber State University and three local high schools. A practical nursing program was initiated with 12 students; Ruby Whitehorse (Navajo) was among them. The students' clinical experience included the 31-bed nursing home that had a large Navajo patient population. In 1997, 13 students, including 7 Navajos, completed the first registered nursing program (McPherson, 1997).

In 1980, Kathleen Morris, director of UNDC, non-profit corporation providing services to San Juan County Navajos, reported that the three UNDC clinics have had 15,000 patient visits in the past year. A $10,000 grant from Atlantic-Richfield Foundation was received that would be used to expand the Montezuma Creek Clinic, on the reservation. This was the initial phase of a larger expansion plan for 5 exam rooms, 2 screening rooms, emergency room, pharmacy,

business and reception room, dental rooms, and ventilation and heating. (San Juan Record, 2/21/80). Russell Stevenson became the new health division director in 10/1980. Four dental operatories were used by MVAH dentists three times per week at Montezuma Creek Clinic. (San Juan Record, 2/21/80).

In 1981, UNDC obtained federal funding channeled through the Navajo Nation funding mechanism to upgrade 89 Navajo homes to include electricity, bathrooms, and kitchen. At this time in San Juan County, a study by UNDC reported that 70% of reservation homes did not have refrigeration, only 23% had flush toilets, and 75% of the respondent s reported hauling water from community wells and other places. (San Juan Record, 7/23/81). At last, sanitation and housing that were so lacking in the past and contributed to third world conditions with its inherent infectious diseases were now being addressed.

New health-related concerns have emerged; there was an increase in substance use among Navajo youth. Using CDC funds from the Utah Department of Health and the University of Utah, Navajo youth were sent for training as drug counselors at the University of Utah. In 1985, Utah Navajo Development Council (UNDC) managed a health clinic in Montezuma Creek that was partially funded by the Navajo Trust Fund and the Indian Health Service.

Ed Tapaha (Navajo), worked for UNDC as a licensed practical nurse and interpreter between 1974 and August 1999 and for some time represented Navajo interests on the Southeastern Utah District Health Department (personal communication 2014). He recalls tuberculosis as a major health problem in the early 70's where "most of the elders were either exposed or had active disease and a doctor from Price came to conduct clinics in southern San Juan County [on the reservation]." (Personal communication, Ed Tapaha, 2014)

Under the Indian Health Service contract health services (CHS), Navajo people were able to use San Juan Hospital in Monticello in the early days. "But it (CHS) became more restrictive under federal guidelines [due to cost restriction] and patients were referred to Shiprock [Indian Health Service]. Some people had a state Medicaid card so they could go to the Blanding clinic where many of them saw Dr. Gibbons. Some went to Dolores or Cortez to get penicillin shots. When they couldn't pay their bills they were refused care. Sometimes people went to the chapter to ask for funds to pay their medical bill." (Personal communication, E Tapaha). In 1989, a legislative audit was conducted and determined that there was mismanagement of funds by UNDC. San Juan County Health District took over the health care management for UNDC. Non-Navajo administrators were now in charge of running Utah Navajo Health Care.

In summary, the 1980's were a decade of change in health care management and changes in disease patterns. The San Juan Hospital changed administrator several times; they had a study conducted and received recommendations which included expansion of board members to be more inclusive of service population, marketing for the entire county and futuristic planning to include the entire county- none of these recommendations were heeded. Blanding Clinic received more Navajo patients due to its accessibility; however, it and San Juan Hospital continued to refer patients to Indian Health Service care if they were unable to pay for services. At the close of the decade, UNDC management was assumed by the San Juan Health Services.

A 1990 report called "Health Services in Blanding: A Plan for Action," was issued in November 1987 by the Blanding Health Board, chaired by Donna Singer, to describe the health needs of the Blanding service area (BSA) in San Juan County. This report was used to justify the need for a birthing center and the beginnings of plans for a second hospital in the county to serve the population south of Monticello, UT where San Juan District Health Services [County

Hospital] was located. Mr. Cleal Bradford was serving as Executive Officer; none of the 7 board members was Native American (Blanding Health Board, 1987).

At the time, the county population was estimated to be 12,621 (6855 Native Americans, 5501 Caucasian, and 261 other); 35% had income less than the 1990 poverty level; 36% of the population were less than 15 years of age, 7% were more than 65 years of age. Native Americans made up 54% of the county population and over 60% in the Blanding Service Area (BSA). The BSA was inclusive of 84% of the county population and was defined as areas that are 45 minutes by ground transportation from Blanding [included the Navajo reservation]. The mission of the board was to "…improve health care services for the community of Blanding and its surrounding service area." (Blanding Health Board, 1987). Population distribution by education and community are displayed in the following table:

Table 1. 1990 Education distribution by community

Grade	Total Count	BSA	MontCreek	Mon Valley	Nav Mtn
<9	1442	909	313	449	84
9-12	1048	881	237	113	54
HS	1381	1267	136	95	19
Some college	1036	972	102	57	7
AD	469	400	11	62	7
Bacc deg	555	491	24	47	17

Selected health characteristics compared between San Juan County and the state of Utah are displayed in the following table:

Table 2. 1990 Selected health characteristics

	San Juan County	**Utah**
Mother<20 y.o.	54 (16%)	3528 (10%)
Native American	259 (75%)	885(2.5%)
LBW (<2500 grams)	16 (4.6%)	2014 (5.7%)
No prenatal care	21 (6%)	112 (<1%)
No 1ST trimester care	140 (40%)	5360 (15%)
No 1st-2nd trimester care	42(12%)	813 (2.3%)
Births to unmarried mom	149 (43%)	4502 (12.7%)
Birth rate	26.6/1000 live births	20.8%/live births
Infant deaths<1 year	14.5/1000 live births	8/live births
Assoc death pre-natal period	<1 (6.5%)	82 (<1%)
MVA	8 (13%)	312 (3.4%)
Other accidents	4 (6.5%)	242 (2.6%)
Suicide	2 (3.3%)	211 (2.2%)

The figure above notes that San Juan County, as compared to the state of Utah, has younger mothers, majority Native American population, greater need for prenatal care, 3 times the rate of unmarried mothers giving birth, almost twice the rate of infant deaths, 3 times the motor vehicle accident and other accidents, and higher suicide rate. The report identified a serious need for one more physician or a Nurse Midwife to achieve the ratio of 1:4500 clinic visits from the current 1:9000 visits. At the time, there were 3 full time RNs, 3 full time Nurse Practitioners, 4 part time RNs, and one physician. Another goal was to improve coordination with other health care providers especially the Indian Health Service to secure contracts to increase utilization of facilities by Native Americans. Goals were identified for patient care services for Outpatient, Hospital, and Long-term Care. This report laid the groundwork for a hospital in Blanding.

Oralee Black, retired nurse, worked for 19 years at the Blanding Birthing Center and 5 years at The San Juan Hospital in Monticello. She spoke about the need for a birthing center as there was a high birth rate among county residents.

"[Navajo] Patients came from all over even from Arizona. Some who were in early labor

were transferred to Indian Health Service [primarily Shiprock, NM]. Three fourths of the patients were Native American. We had about 1700 deliveries in 19 years. Some of them were not enchanted with the IHS. They used Medicaid or private insurance but some couldn't pay. I saw a lot of Native Americans at Monticello [hospital.] We were not always able to admit 'IHS patients.' They were the ones who had no source of income or insurance - it was bad for us and bad for our patients. As soon as we stabilized them, we transferred them out. Everywhere I worked, I worked with Native Americans [patients]- in the hospital, birthing center, and the clinic [in Monticello.]" We offered labor and delivery classes, WIC, and Baby Your Baby.[1] WIC and Baby Your Baby aren't active anymore. There was family planning but there wasn't time and resources in the clinic setting. We had some medical students rotating through the clinic." (Personal communication, Ora Lee Black, 2014)

"Some of the challenges we faced…. Language barrier isn't as great as it used to be; now the younger generation is not learning Navajo; they're losing the heritage. The younger people are not learning Navajo and there's a communication problem with parents. Health conditions are not getting much better. For all people, the underlying mentality is that they don't take ownership of their own illness, their health, and their body. The positive is that a greater percentage of Navajo and Utes are becoming more educated, they have access to the local college, but none of those students are rotating through the clinic." (Personal communication, Ora Lee Black, 2014)

Between 1997 and 2007, the Navajo Nation Division of Health, in coordination with the Centers for Disease Control (CDC, 1997-2007), assessed various behavioral parameters

[1] WIC is a federally funded nutrition program for Women (pregnant, newly delivered, or nursing), Infants, and Children. Baby your Baby was a Utah Department of Health program.

including unintentional injuries and violence, tobacco use, alcohol and drug use, sexual behavior, dietary behavior, physical activity, and weight control. The following figures show results of the Navajo High School Youth Risk Behavior Survey, for 1997 and 2007, respectively:

38.3% to 31% reported riding with a driver who had been drinking alcohol in the past 30 days;

33% reported feeling sad almost daily for 2 or more weeks in the past 12 months;

20.7% to 20.4% seriously contemplated attempting suicide;

84.9% to 70% ever tried smoking;

45.7% to 34.2% currently smoked cigarettes at least 1 day in past 30 days;

74% to 63% ever had at least one drink of alcohol;

44% to 35% currently drank alcohol;

42% (2007 only) obtained alcohol by someone giving it to them;

65% to 59% ever used marijuana; 33% currently used marijuana;

36.4% to 27% were offered, sold, or given an illegal drug on school property;

25.5% to 27% were currently sexually active;

46% to 38% did not use a condom;

88.2% to 93% did not use birth control;

16.2% to 31% were never taught in school about AIDS or HIV;

86% (2007 only) drank non-diet soda or pop in the past 7 days;

55% (2007 only) were not physically active at least 60 minutes per day in the past 7 days;

40.4% (1999) to 32% watched television 3 or more hours per day;

68% to 71% did not attend physical education classes on all 5 days in an average week;

12% (1999) to 16% considered themselves to be obese;

17.7% (1999) to 18% considered themselves to be overweight; and

53.3% to 48% were not to trying to lose weight.

The Navajo High School Youth Risk Behavior Survey (YRBS) was administered by Navajo Nation under the auspices of the CDC and included all of the Navajo reservation, including San Juan County's Utah Strip. Although many variables above showed a change in a favorable direction, between 1997-2007, in this population of Navajo high school students, there was a need for more culturally appropriate health education in all areas that were surveyed. These areas include smoking, use of drugs and alcohol, unprotected sexual activity, suicidal thoughts, lack of physical activity, overweight, and nutrition intake. These data are self-reported by a sample of Navajo Nation youth including youth from San Juan County, Utah, however, grouped data specific to Utah Navajo youth were not available. However, it is safe to generalize these data to Utah Navajo youth. These are public health issues that should require collaboration among health care providers, public health organizations, and public leaders to identify and implement appropriate interventions. It appears that none of the local health care providers nor the San Juan County health had addressed them.

One local health activist to speak for inclusion of Navajo access to local health care systems was Donna Singer, a Caucasian woman married to a Navajo man, Lewis Singer. In an 2014 interview with the Singers, they spoke of how they fostered several Navajo teens while they attended schools in Blanding. These were students from as far away as Navajo Mountain who would not otherwise have access to education. Ms. Singer was employed by San Juan County District Health Services as a radiology technician, traveling throughout the county to conduct ultrasound tests at clinics and hospitals. She was dismissed in 1991 from her employment. She was later employed by the Blanding Clinic. These experiences were to provide her with perspectives as a patient advocate that Native American patients were "falling through

the cracks" and a better health care system that was inclusive of all of San Juan County residents was needed. (Donna Singer, Personal communication, 2014; July 2015).

One of these experiences is one that she will never forget and to this day cannot believe that it ever happened. Prior to her dismissal as an employee of the hospital, she received a call from a doctor from MVAH in Monument Valley, She said it was a stormy night and the doctor told her he needed an ultrasound on a Navajo patient but he didn't want Ms. Singer to have to drive the distance between Monticello and Monument Valley. So, the doctor drove the patient by ambulance to Monticello. Both the patient and doctor were refused admittance to the emergency room of San Juan Hospital. Ms. Singer then took the ultrasound machine to the parking lot and took ultrasound readings in the ambulance! The rationale given for refusal of care was that the patient was an "IHS patient" and non-paying while the doctor did not have hospital privileges at San Juan Hospital. (Donna Singer, personal communication 2015). In 2000, she was invited by Mark Maryboy to assist with developing a better Navajo-owned health care program. At the time, UNDC was overseeing some small clinics that were funded by the Indian Health Service and the Utah Navajo Trust Fund. These programs were moved from IHS control to tribal control through a PL 638 process to make them more efficient. Eventually, local Navajo leaders along with Ms. Singer developed the Utah Navajo Health Systems in 2000. Mary Maryboy (personal communication, 8/20/14) recalls that there were no prevention efforts taking place through UNDC but providers were only meeting the immediate needs of those who came to the clinic. He added that health conditions at this time included heart disease, diabetes, kidney failure, cancer, high cholesterol, and stroke. Most couldn't afford care but went to hospitals that would provide them care including Monticello (San Juan Hospital), and driving long distances to Moab, Cortez, Colorado, Shiprock New Mexico, IHS, and Tuba City, Arizona, IHS. Some used Medicaid,

Medicare or private insurance. For the majority their only option was Indian Health Service care that meant long distance travel. "People weren't getting good quality health care, and they had no say in it," Maryboy says. "Now[in 2014], we're [UNHS] doing just the opposite."

Over the next few years, the UNHS grew so successful that the clinics became recognized as federally qualified community health centers (CHC) with federal funding status. The CHCs replaced the locally operated UNDC clinics that used primarily federally-funded Indian Health Service funds. Federal Qualified Health Center (FQHC) is defined by the Rural Assistance Center as: "…outpatient clinics that qualify for specific reimbursement systems under Medicare and Medicaid. FQHCs include federally-supported health centers (both grantees and Look-Alikes) as well as certain outpatient Indian providers. Note that different rules apply to outpatient Indian providers who enroll in Medicare or Medicaid as FQHCs."

In addition, these centers must first meet several criteria to qualify including the following:

• Offer services to all persons, regardless of the person's ability to pay

• Establish a sliding fee discount program

• Be a nonprofit or public organization

• Be community-based, with the majority of their governing board of directors composed of their patients

• Serve a medically underserved area or population

• Provide comprehensive primary care services • Have an ongoing quality assurance program .[2]

These health centers are located in Montezuma Creek, Monument Valley, Navajo

[2] (Rural Assistance Center: https://www.raconline.org/topics/federally-qualified-health-centers)

Mountain, and Blanding.

In addition, UNHS also used the 1975 Indian Self-Determination and Education Assistance Act (ISDEAA) (Pub. L. No. 93-638) process to shift from an IHS-funded and controlled program to a more independent management system to operate the health centers. According to the Office of Tribal Self Governance, "it is an expression of the nation-to-nation relationship between the United States and each Indian Tribe. Through the Tribal Self Governance Program (TSGP), Tribes have the option to assume IHS program funds and manage them to best fit the needs of their Tribal communities. Tribes participating in the TSGP negotiate with the IHS and take on full funding, control, and accountability for those programs, services, functions, and activities (PSFAs), or portions thereof, that the Tribe chooses to assume."[3]

In 2014, the UNHS had a full-time staff of 124 and served more than 10,000 patients, most of them in the southern portion of the county. "It's a huge success," Singer says. "It's an example of what the Indian people can do when there are no barriers to hold them back." (Donna Singer, Personal communication, 2014).

In the early 1990's, the possible closure of the White Mesa (Uranium) Mill, located south of Blanding, was of concern to San Juan County leaders as the "welfare rate was 36.8%" and people needed employment (San Juan Record 1/6/92). At the same time there were concerns about radiation and uranium exposure throughout San Juan County resulting in cancer and other serious health conditions for Navajos. Radiation cleanup had just been completed in Halchita (San Juan Record 1/18/92), tailings cleanup bids were solicited, and a public hearing was scheduled for a Monument Valley/Oljato cleanup. The County passed a resolution in March 1992 for a feasibility study to build a Monitored Retrievable Storage Facility. American Indians

[3] http://www.ihs.gov/selfgovernance/aboutus/me

were adamantly opposed to keeping the mill open. Eventually the mill was closed.

Another health concern among the Utah Navajo is unintentional injury which, in general, tend to higher in rural areas for a number of reasons. A study was conducted covering the period between January 1994 and June 1996 in Montezuma Creek area (Billie, 1996). The closest hospital is 60 miles to San Juan Hospital and the closet Level II equivalent trauma center is in Farmington, NM, 90 miles away. Although a total of 259 ambulance runs were documented, this report only looked at injuries with E codes 800-999 which includes fall, falling objects, motor vehicles crashes (MVC), and assault. Using this criteria a total of 36 patients were included. Injuries reported included MVC (50%), falls (19%), pedestrian injury (14%), and assaults (8%). A total of 18 patients were transported by ground ambulance, 4 were transported from the scene directly by air ambulance, and 14 were transported by ground ambulance but later by air ambulance. Nine different hospitals within the Four Corners region were used for needed transfers; the Blanding clinic served as medical control.

The results of the study showed that median injury severity score (ISS) was 9.0, the average score was 10.6, the range was 1-34. The average hospital stay for ISS less than 15 was 6 days and for ISS greater than 15 was 10.2 days. Of the 36, 8 had an ISS of greater than 15. The study revealed that only EMTs, not paramedics, are available in a rural areas. Recommendations were made that included: improve pre-hospital response time by expansion of EMT training, and well as mapping, marking, and maintaining roads. Patients were not limited to Navajo but were county and non-county residents, and Indians and non-Indians. This study was conducted about the time Monument Valley Adventists Hospital closed and long before the Blue Mountain Hospital opened.

Trauma level categories range from Level I to Level V with Level I serving as a regional hospital or medical center capable of providing total care for every aspect of injury – from prevention through rehabilitation. Trauma level V provides initial evaluation, stabilization and diagnostic capabilities and prepares patients for transfer to higher levels of care. (American Trauma Society[4].)

The efforts of Mark Maryboy and Donna Singer came to fruition in San Juan County in the early part of this decade. UNDC had operated small health clinics in Montezuma Creek, Oljato, and Navajo Mountain using Navajo Trust Funds, Indian Health Service funds, and other sources of funding. UNDC was a private, non- profit organization that was incorporated in the state of Utah in November 1971 to provide services to the Navajo people in San Juan County. The Utah Navajo Trust Fund was created by an act of the U.S. Congress on March 1,1933. That act transferred public land in San Juan County to the Navajo reservation, but provided that the state would receive 37 1/2 percent of any oil and gas royalties from the land transferred in behalf of Utah Navajos. The 1933 act, as amended, limits how the state may use the Navajo royalty funds it received. The funds may be used only "for the health, education, and general welfare of the Navajo Indians residing in San Juan County."[5]

Mark Maryboy and Donna Singer began collaboration to bring the Montezuma Creek and Monument Valley clinics under a Public Law 638 program an Indian Self determination Governance law. This meant Indian Health Service funds could go directly to the clinics and making it a more efficient operation rather than funds being funneled through the Shiprock IHS.

[4] http://www.amtrauma.org/?page=traumalevels
[5] http://le.utah.gov/audit/91_10dig.pdf

In 2001, the clinics in Blanding, Oljato, Montezuma Creek and Navajo Mountain clinic were designated Community Health Centers under the umbrella of Utah Navajo Health Systems, a non-profit 501c3 to provide medical, dental, and behavioral health services. And they could receive additional federal funding, provide better access to necessary medical care, and serve non-Indians as well. At this time, they received the Special Diabetes Program for Indians, a federal Indian Health Service grant, along with other funds to become a self-sustaining program throughout San Juan County. By 2014, UNHS employed 290 full time and part time staff, about 80% were Native American. (personal communication, Mike Jenson and Byron Clarke 2014).

In 2006, the Indian Health Service facility, Four Corners Health Center in Red Mesa, AZ, was built as a means to provide health care to people living in Red Mesa, Teecnospos, Mexican Water, and some outside of Montezuma Creek. The communities of Red Mesa and Teecnospos straddle the Arizona and Utah state lines; Red Mesa chapter houses is located inside Utah while Teecnospos chapter house is located in Arizona; and they are both included in the Navajo Utah Commission.

The report by the Utah Department of Health Multicultural Health called *Health Status by Race and Ethnicity 2010* was issued in March 2010; data for this report cover the period 2006-2008. Between the years, 2006-2008, the American Indian/Alaska Native population (AIAN) was 44,701 or 1.7 % of the 2,663,500 total Utah population; Hispanic/Latino made up the largest ethnic minority population at 11.5%. This report looked at many factors of importance to the health status of AIAN people. As there were no specific numbers or rates for San Juan County, one can only assume that the figures for AIAN are fairly similar to those of AIAN in San Juan County. Here are findings from this study:

1. Life Expectancy: The life expectancy at birth for AIAN was 76.7 years as compared to Utah at 78.9. Life expectancy at birth is influenced by deaths of younger age groups. AIAN has the highest non-intentional injury-related death and violent death of all Utah racial and ethnic groups; this fact may influence their life expectancy.
2. Poverty: Between 2006-2008, 10% of all Utahns were living in poverty; AIAN had the highest poverty rate at 22.1% of all race/ethnicity groups. The 2009 poverty guideline by the Department of Health and Human Service (DHHA) for a family of four was $22,050.
3. Child Poverty: Between 2006-2008, 11.1% or more than 91,000 of Utah children were living in poverty. AIAN had the highest rate of child poverty at 25.9% among all races and ethnicity groups.
4. Insurance Coverage: For 2006-2008, while 10.3% of all Utahns reported having no health insurance, 17.9% of AIAN had no health insurance coverage. AIAN and Hispanics had the highest rate of no insurance coverage among all race and ethnicity groups. Indian Health Service is not a health insurance.
5. Inability to access health care: Between 2006-2008, 15.2% of all Utahns reported not being able to access health care, 37% of AIAN had significantly higher rates of inability to access medical, dental or mental health care in the past year.
6. Emergency department point of access to medical care: Between 2006-2008, 6.6% of all Utahns reported using the emergency department or urgent care as their point of access to medical care; AIAN were 2.2 times more likely (or 14.6%) not to have a primary care provider.
7. Prenatal care: In 2008, while 79.1% of all Utah live births received first trimester prenatal care, 56.2% AIAN did not.

8. Pap test for cervical cancer screening: During 2004, 2006, and 2008, 76.3% of Utah women age 18 years and over reported receiving a Pap Test, 66.5% of AIAN woman did not.
9. Breast cancer screening: During 2004 and between 2006-2008, 65.8% of women 40 years and over reported having had a mammogram in the last two years, 50.9% of AIAN did not, a significantly lower rate than the state rate.

The following are risk factors for illness or Injury; the report doe AIAN were as follows:

10. Overweight or Obesity: Between 2003-2008, 58.4% of all Utah adults were overweight or obese; significantly more AIAN (75.7%), Blacks (69.7%), and Native Hawaiian or Pacific Islanders (78.9%) were overweight or obese. Overweight and obesity contribute to heart disease, some cancers, diabetes, stroke, arthritis, and depression.
11. No physical Activity: From 2003-2008, 19.3% of Utah adults reported not being physically active; significantly more AIAN (29.4%), Blacks (28.2%), and Hispanic/Latino (33.2%) were physically inactive. Physically activity helps prevent heart disease, diabetes, slows bone loss in advancing age, lowers risk for certain cancer, and helps reduce anxiety and depression.
12. Cigarette Smoking: between 2003-2008, 10.6% of Utah adults reported smoking; AIAN (19.5%), Blacks (21.2%), and Hispanic/Latinos (12.7%) reported significantly higher rates of smoking. Smoking increases the risk for chronic lung disease, coronary heart disease, stroke, and a number of cancers including lungs, larynx, esophagus, mouth cervix, pancreas, bladder and kidneys.
13. Exposure to Secondhand Smoke: From 2006-2008, 3.3% of Utahns reported exposure to secondhand smoke in their homes; AIAN had significantly higher rates (8.6%)

secondhand smoke in the home. Exposure to secondhand smoke is linked to heart disease, lung cancer, and respiratory illnesses.

14. Binge Drinking: From 2005-2008, 8.5% of Utah adults reported binge drinking in the past 30 days; AIAN and Hispanic/Latino had significantly higher rates at 14.6% and 12.2%, respectively. Binge drinking is defined as 4 or more drinks on one occasion for women and 5 or more drinks on one occasion for a man.
15. Binge drinking can lead to increased risk for certain cancers, stroke, liver damage, damage to a developing fetus in a pregnant woman, increased risk for motor vehicle traffic crash, violence, and other injuries; and coma or death.

The following are considered Protective Factors for Health and AIAN results are as follows:

16. Daily Fruit Consumption: For 2003, 2005, and 2007, 31.3% of Utah adults reported eating 2 or more servings of fruit daily; 30.1% of AIAN reported daily fruit consumption (70% did not eat recommended amount of fruit).
17. Vegetable Consumption: For 2003, 2005 and 2007, 23.3% of Utah adults reported eating 3 or more servings of vegetables daily; only 15.5% of AIAN reported daily vegetable consumption (84.5% did not eat recommended amount of vegetable).
18. Knowledge of Stroke Symptoms: For 2003, 2005, and 2007-2008, 39.2% of Utah adults know the signs and symptoms of a stroke and would call 911 as compared to 32.3% of AIAN (about 1/3). Knowing the signs and symptoms of a stroke, calling 911, and getting to a hospital are crucial for the best outcomes. Stroke can cause permanent and significant disability.

The following factors relate to the Health of Mothers and Infants and AIAN results were:

19. Preterm Birth: In 2008, 9.7% of all Utah live births were preterm; while Blacks had a significantly higher rate (13%), AIAN and NH/PI rates were 10.9%. Preterm birth is

defined as birth less than 37 weeks gestation [40 weeks is term birth]. Preterm birth is the leading cause of perinatal death; and they have increased morbidities, often requiring intensive care after birth.

20. Smoking during pregnancy: From 2007-2008, 4% of Utah childbearing women smoked during the third trimester of pregnancy. Blacks (7.9%) had a significantly higher rate of smoking followed by AIAN at 5.1%. Cigarette smoking during pregnancy increases the risk for complications including premature rupture or membranes, preterm birth, stillbirth, low birth weight, neonatal death, and Sudden Infant Death Syndrome (SIDS).
21. Gestational Diabetes: In 2008, 3.1% of all Utah births were affected by gestational diabetes; this rate was significantly higher in AIAN at 7.2%. Gestational diabetes is diabetes diagnosed during pregnancy, characterized by insulin resistance; it increases the risk of complications for both mother and infant including pregnancy-induce hypertension, Cesarean delivery, and preterm birth.
22. Births to Adolescents: In 2008, the rate of Utah girls age 15-19 who gave birth was 33.9per 1000 live births. For AIAN, this rate was 53.1/1000 live births. Higher rates were reported for Hispanic/Latino (113.4) and Native Hawaiian/Pacific Island girls (60.1).Babies born to adolescent mothers are at risk for infant mortality and low birth weight. Giving birth during adolescents is associated with limited educational attainment that can negatively affect future employment and earning potential.
23. Unintended Pregnancy: From 2004-2008, 32.7% of Utah childbearing women reported unintended pregnancies. All ethnic groups except Asian, had significantly higher rates of unintended pregnancy including only live births.

Again, these are public health data; statistics show the tremendous need for improvement in the health of AIAN populations throughout the state of Utah. In the 2000's the pendulum has shifted from small clinics with limited funding attempting to serve the challenging needs of Navajo people's health to better funded and more efficient community health centers providing comprehensive health care through out-patient facilities located strategically in Blanding, Montezuma Creek, Monument Valley, and Navajo Mountain.

A frontier area is defined as 6 or fewer person per square mile. In 2014, San Juan County's population density was 1.9 persons per square mile; its land area is about 7,820 square miles. The 2014 population is estimated at 15,251 by the US Census (2014). Socio-economic figures included per capita money income in past 12 months for San Juan County as $15,476 as compared to $23,873 (State of Utah); median household income for San Juan County was $40,492 as compared to $58,821 for the State Of Utah; and persons below poverty level for San Juan County was 27.1% as compared to 12.7% for the State of Utah. A 2013 Utah Health Status update report called, Underserved Populations: Utah's Health Professional Shortage Areas, noted that most of Utah is non-urban and of Utah's 29 counties, 27 are designated as full-county or partial-county primary care Health Professional Shortage Areas (HPSAs). San Juan County was not designated because it did not meet the required population-to-provider ratio for a geographical area primary care at ≥ 3500:1 or for low-income population-to-provider ratio of ≥ 3000:1. Presumably, San Juan County has now achieved a better primary care provider ratio than the HPSA requirement! An HPSA is a measure of a shortage of providers serving an underserved population in a county, a group of census county divisions, or a group of census tracts. HPSAs are designated for three different disciplines: primary care, dental care, and mental health.[6]

[6] http://health.utah.gov/opha/publications/hsu/1309_Underserved.pdf

For dental health, San Juan county was one of 6 frontier counties to get a low-income population, full county designation. This required a population-to-provider ratio of ≥ 4000:1. For mental health, San Juan County was 26 of the 29 counties designated as full-county geographical area HPSAs. This required a population-to-psychiatrist ratio as a HPSA designation of ≥ 30,000:1. Thus, from this report San Juan county is doing well in terms of the primary care providers but not for dental and mental health providers.

One unique feature of frontier areas of Utah in 2013 was that they had the highest birth rate to unmarried mothers at 265.0 per 1000 live births (n=438). In 2013, out of a total of 256 births in San Juan County, 112 or 44% were Native American and 100 or 39% were white; the remainder was Hispanic, Black Asian or other races. There were 2 fetal deaths in SJ Co in 2013, one was Native American. There were 88 deaths overall, 34 or 39% were Native American, 40 or 45% were white, and 14 or 16% were Hispanic thus overall, the majority of deaths were among ethnic minority population (54%). A total of 8 deaths were due to unnatural causes including motor vehicle, other accident, suicide, and events of undetermined intent. According to the County Health Rankings & Roadmaps: Building A Culture of Health, County by County, a Robert Wood Johnson Foundation Program (RWJP), in 2014, San Juan County did not rank well as compared to other Utah counties.[7]

1. For overall Health Outcomes, San Juan County ranked 16th among 27 counties; 2 were not ranked. Health outcomes are based on equal weighting of length and quality of life. Emery (21st), Grand (22nd) and Carbon (27th) counties were ranked below San Juan; all were located in the same Southeastern Utah Health District in 2014. Health Outcomes

[7] http://www.countyhealthrankings.org/app/utah/2014/rankings/sanjuan/county/outcomes/overall/snapshot.

were measured by: Length of Life (premature death) and Quality of Life (poor or fair health days, poor physical health days, poor mental health days, and low birth weight.) Thus, San Juan County faired better within the Health District but not as well as 15 other counties in the state.

2. For Health Factors Ranking, San Juan County was last, ranked 27th out of 27 counties in Utah; again 2 Utah counties were not ranked. Health Factors were based on weighted scores for health behaviors, clinical care, social and economic factors, and the physical environment.
3. Health behavior parameters include Tobacco use (adult smoking); Diet and exercise (Adult obesity, food environment index, physical inactivity; access to exercise opportunities); Alcohol and Drug use (excessive drinking, and alcohol-impaired driving deaths); and Sexual Activity (Sexually transmitted diseases and teen births). San Juan County was 27th.
4. Health Behavior also includes Clinical Care: Access to Care (uninsured, primary care Physician; dentists, mental health providers); Quality of Care (preventable hospital stays, diabetes screening, mammography screening). San Juan County was 27th.
5. Social and Economic Factors including Education (high school graduation and some college); Employment (unemployment); Income (Children in poverty); Family and Social Support (inadequate social support and children in single parent households); Community Safety (Violent crimes and injury deaths). San Juan County was 27th.
6. Physical Environment include Air and Water Quality (air pollution- ad particulate matter and drinking water violations) and Housing and Transit (severe housing problems,

driving alone to work, long commute-driving alone). San Juan county ranked 6th out of 27 counties.

One concern that supports poor child health above and was often mentioned in the interviews with community members was the large presence of female-headed household in which Children are abandoned by their fathers among the Native American population. These are complicated issues that are related to social determinants of health. Socio-economics, employment, housing, education, and child poverty are all factors that are mixed in with the health of families particularly those observed as female-headed households.

In summary, the 2010's has brought in some opportunities to improve the health of American Indians and other residents of San Juan County. A fairly new Blue Mountain Hospital and community health centers operated by Utah Navajo Health Systems and the newly established health department are all entities that ought to have positive impacts on the health status statistics that are presented above.

There are a variety of health care organizations currently operating in San Juan County, Utah, that provide some services to Navajos:

Utah Navajo Health System (UNHS) remains a driving force behind health care for Navajo people in San Juan County, Utah. In 2013, UNHS reported that they provided 69,984 patient encounters (number of visits) to 12,875 individual patients whose payment status are as follows: 37% uninsured, 24% Medicaid, 10% Medicare, and 29% other. UNHS estimates its economic impact in the county as substantial. They offered employment to 197 FT positions and supported 155 jobs in other industries for a total of 352 jobs. This was estimated to have impacted the economy by $40,407,544 ($21,627,673 direct and $18,779,871 indirect). Moreover, UNHS estimated that their tax impact was such that they contributed approximately

$1.6 million to the state and county tax revenue and $3.0 million to the federal revenue; a total of 4.4 million in total tax impact (Byron Clarke, 2014).

Blue Mountain Hospital, Inc., a private non-profit 501(c)(3) corporation, opened its doors for business in July 2009 to meet heretofore unmet inpatient health needs, particularly among Native Americans in San Juan County. The Ute Mountain Ute Tribe, Utah Navajo Health Systems, and a private enterprise donated funds for the construction of the hospital. Both entities have representatives on the Board of Directors. In 2015, Lynn Stevens a former San Juan county Commissioner who had been instrumental in the planning of the early efforts to seek health care for communities from Blanding and south joined the Board of Directors (Blue Mountain Hospital newsletter, 2015). In 2014, Blue Mountain Hospital hired National Rural Health Resource Center (Duluth, MN) to conduct a community health needs assessment survey to "determine the utilization and perception of local health services" of its customers. A total of 800 questionnaires were mailed to 7 zip codes; the response rate was only 21% as follows: Blanding (63%), Monticello (16%), Montezuma Creek (8%), Bluff (6%), Monument Valley (3%), and Mexican Hat (1%). Only 19 respondents were from reservation communities in south San Juan County. Of the respondents, 49 (32%) stated they were healthy and 78 (51%) stated they were somewhat healthy; 26 (17%) responses were not noted. [One wonders if those not responding had poor health.]

The most serious health concerns were reported as diabetes by 96, cancer by 81, and alcohol/substance abuse by 64 persons. A total of 105 (69%) reported having received hospital care in the past three years; 61% were received at Blue Mountain and 25% were received at San Juan Hospital. A total of 70 (46%) rated the services to be good; 38 (25%) rated it fair; 45 (29%) were not reported. The age distribution was 36 to 85 years of age; 60% were in the 56-85 age

groups while 20% were in the 26-45 age groups; 20% or the younger than 26 age groups were not reported. The recruitment for the survey could have been better conducted in the south; the research group should have been advised that mailed surveys to remote areas of the reservation would not work.

San Juan Health Service District (San Juan Hospital, historically, has experienced persistent and chronic administrative, financial, and physician supply problems as described in County Commission minutes and local newspapers, the San Juan Record and the Panorama. (San Juan Record, April 9, 2014). In January 2014, three physicians resigned and CEO's contract was not renewed. An electronic medical records system was purchased for $1.2 million that included a $29,000 monthly service fee. Changes were made to lessen the physicians' workload by bringing in some mid-level practitioners to handle emergency room calls; coordinate with Blue Mountain Hospital and Utah Navajo Health System; and assistance was received from hospitals in Salt Lake City, specialists in surrounding areas, and the Utah Department of Health. A new mission statement was developed stating, "By duplicating and coordinating staff, processes and programs, all organizations will benefit by reducing duplication of programs and allowing patients greater choice and access throughout the county." Some of the specialty care available includes cardiology, general surgery, OB/GYN for high risk patients. Tele-health is coordinated with the University of Utah for stroke and burn care. (Personal communication, LShafer, 8/28/14).

We have an abundance in nursing supply; no problem since the [College of Eastern Utah, now USU-Blanding Center] college opened the program in about 1989. We have three mid-levels [practitioners]. Two representatives from Blanding and Monument Valley sit on the [hospital] board. According to its website, San Juan County Hospital states that: "San Juan

County Hospital originally began in 1947 in a converted mining office with 16 beds that served all San Juan County (Utah). In 1960 the hospital was built at its present location and increased its capacity to 37 beds. In 1988 the San Juan Health Services District was created as a special services district under the County's umbrella. In 2006 it became a 25 bed Critical Access Hospital and still provides healthcare to all of San Juan County (Utah) as well as parts of western Colorado, northern Arizona and New Mexico. San Juan Health Services District includes not only the hospital but has physician clinics in Blanding and Monticello. Additional space, current technology and remodeling have kept the physical facility and equipment current and capable of meeting today's healthcare needs."[8]

San Juan County Health Department was established in 2015. Prior to February 2015, San Juan County was one of four counties making up the Southeastern Utah District Health. In the Annual Report, 2012, by Southeastern Utah District Health Department (SEUDHD), three of its 12 Board members represented San Juan County: Commissioner Phil Lyman, Gary Suttlemyer, and Steve Young, all of whom are white people. The SEUDHD's mission is "to assist the residents of the Southeastern Utah District Health Department in achieving and maintaining optimal health." Its vision is that "Communities in which all citizens live long and healthy lives."

While the SEUDHD's public health nurses (PHN) served as school nurses in all 4 counties, San Juan County chose to provide school health through the school district. PHNs provide a number of services for students including vision screening, scoliosis screening, immunization tracking and reporting, maturation classes, nutrition, dental health and personal hygiene. In addition, they offered programs for the staff including CPR classes, TB skin tests,

[8] http://sanjuanhealthservices.org/html/history.html

immunizations, flu vaccinations, and blood pressure checks (Worthy Glover, personal communication, 2015). The SEUDHD assigned to San Juan County 2.50 FTE nurses, 1.75 FTE clerks, and 1.0 FTE environmental health specialist, a total of 5.25 FTE out of the total 33.00 FTE for SEUDHD. One major event that SEUDHD held in the Four Corners was the annual Injury Prevention Summit. Its 6th annual event reached at least 3000 individuals with general injury prevention messages, at least 1000 youth with teen motor vehicle awareness messages, and 129 fall prevention equipment were placed. Their Annual Report showed photos of the event in Monument Valley with Navajo participation. In 2012, they recorded for San Juan County 200 births (25% of births in the district) and 118 deaths (19% of the deaths in the district).

The Children with Special Needs Health Care program is a state-operated clinic that travels a team to rural Utah to conduct clinics that offer services in audiology, nursing, developmental pediatrics, social work, psychology, speech/language, genetics, neurology, and occupational and physical therapy. In 2012 a total of 57 children were seen in San Juan County clinic in Blanding and Montezuma Creek clinic. The report didn't specify the number of Navajo clients seen in Blanding and Montezuma Creek (SEUHD, Annual report, 2013).

Another program that the SEUDHD was involved in since 2008 was the Victims of Mill Tailings Exposure (VMTE). Between 2008 and August 2012, 969 people participated in the cancer education and /or screening program. The Annual Report noted that 26 cancer diagnoses were made by medical providers who have participated; race and ethnicity were not reported.

The Utah Navajo Health System (UNHS) diabetes program noted that in 2014, there were 807 Native Americans with diabetes 59% (475) were female and 41% (332) were male. Overweight and obesity are major health problems associated with type 2 diabetes. Over one-half, 425 or 53% of those with diabetes were obese with a Body Mass Index (BMI) of greater

than 31; 272 or 34% were overweight; and 111 or 14% were of normal weight for their height (BMI of 25 or less). The majority of those with diagnosed diabetes are 45 years or older (681 or 84%). A total of 125 or 15% were between 15-44 years of age. (personal communication, Nick Fox, diabetes coordinator, 4/22/15). UNHS is well staffed with pharmacists, medical doctors, registered nurses, 2 dietitians, a diabetes coordinator in each clinic, and 2 podiatrists.

UNHS is today the primary health care provider for Navajo people in San Juan County through its four community health centers located in Montezuma Creek, Navajo Mountain, Monument Valley, and Blanding. Among its direct care providers are three Navajo-speaking professionals- 2 Physician Assistants and 1 physician. The mission statement of UNHS is "UNHS will make a significant impact in the quality of life for all community members by providing safe high quality comprehensive and linguistically competent care while maintaining fiscal viability." Its vision is that it "will develop and expand health care services and community partnerships while improving economic opportunities for all communities." UNHS is available to provide care to anybody and is not limited to Native Americans or Navajo people.[9]

St. Christopher Mission continues to offer services as needed for today's social challenges. Currently, they offer summer programs for children in art, cooking, finance, and decision making so as to prepare them for the future. RSteve (personal phone communication, 2015) indicated the need for a women's shelter as he receives calls and even some women with children appearing at their door asking to assistance with housing.

Utah State University – Blanding Center has its beginnings in the 1970's when its founders realized the dire need for education among the Utah American Indian population (McPherson, 1997). Among several careers promoted was a nursing program that initially

[9] (http://www.unhsinc.org/).

educated some Licensed Practical Nurses, however, a two –year associates degree program for registered nurse program was eventually. Today, students are introduced to other health professions and have guest speakers from local clinics (Michelle Lyman, 2015), Ms. Lyman is a Physician's Assistant with UNHS and also serves as the Director of Health Professions at the USU-Blanding Center. She offers a careers exploration class for students and has a number of professionals as guest Speakers. Referring to students from the reservation, she noted, "they do not enter health careers because they feel they cannot become one."

In-person and telephone interviews were conducted with Navajo people living the area as well as current and former non-Navajo program directors in San Juan County. These interviews reflect some of the continuing problems experienced by Navajos in San Juan County regarding politics and divisive practices.

Mark Maryboy: "We worked hard with Donna [Singer] on health care and she has done a good job but she still thinks like a white person, takes care of her whites first. She could have hired Navajo administrators [for UNHS or Blue Mountain Hospital] but she hired her whites and family members while she was CEO [even though there's a Navajo preference law]." (Personal communication. 8/20/14)

Mark Maryboy: The county collects taxes from us but they all go to north county and used there, [not in south county]"

Elsie Dee: "The need for preventive dentistry is great. Peds dentists came from the University of Utah once and they were kept busy even into the evening with babies and children." This event took place at the UNHS clinic in Montezuma Creek. (Personal communication, 8/20/14).

Elsie Dee: "School inequality issues continue. We have a white superintendent and some white principals who don't understand us or our needs. We request travel to the National Indian Education conference or to the Johnson O'Malley conference but they are not approved. These conferences deal with Indian Education issues."

Elsie Dee: "Our wrestling team needs uniforms but there are no funds to get them nice looking athletic uniforms like other schools do."

Aneth Chapter meeting: The same issue with atheletic uniform was discussed at one Aneth Chapter meeting (5/08//2014). The chapter officials approved $4500 and asked for donations to purchase wrestling team uniforms; total needed was $8900.

Navajo Deacon of St. Christopher Mission: Domestic violence is a problem- we get some women and children asking for help. One lady went to Blanding for help but she couldn't use the center with her kids; she has to be alone [without kids] to use the center. And on top of that, they are only open 8-5. I guess you have to limit domestic violence to those hours.

Edward Tapaha: In the 1970's Dr. Ray Cowley from Price health department came to do TB clinics; I got involved as interpreter and made home visits with the medical team. We had an old x-ray machine at Montezuma Creek Clinic. Utah Navajo Trust Fund built the clinic under state workforce and contracted with doctors and nurses, matched by Indian Health Service.

Ed Tapaha: Before the 70's, people used contract health service and used San Juan hospital. In the 70's contract health got more restrictive and they couldn't get IHS to pay for hospital stay. The only way was to get a state Medicaid card, if they qualified. The only time they were refused services is when they neglected to pay their [hospital] bill. Sometimes they went to the chapter to ask for funds to pay for private care. They went to Cortez or Dolores for

shots. When the hospital was in the red, they were turned away as "IHS" patients [who couldn't pay].

Former County Commissioner Lynn Stevens: Years ago the San Juan County Service District was challenged to do more for the Navajo. There was no certification to get reimbursement for Navajo patients; Navajo patients were "rejected at the front desk." "Today health care among the Navajo is excellent." The Navajo Trust Fund and federal dollars helped build the UNHS clinics. The Utes and UNHS pitched in to build the Blue Mountain Hospital; it's a positive relationship (personal communication, 2015).

Former County Commissioner L. Stevens: Some of the health problems that I'm aware of are uranium related cancer, alcoholism, use of drugs, diabetes, obesity, injury, mental health, one parent families, no man in the house. The West Water population is a "homeless population." There are 23 home sites on 110 acres. Blue Mountain is not recognized as a chapter by Navajo Nation; they seek services from Aneth Chapter; they have no running water or electricity; it's not reservation land but deeded land. (Personal communication 2015)

Laurie Shafer, former hospital administrator: We see OB and ill Navajo patients and get approval from Shiprock (IHS]; if not approved, we send them to Shiprock. We saw a lot before and the number dropped since Blue Mountain opened. Some challenges we have are: keeping physicians in rural area, regulatory situations, Blue Mountain medical center opening affected our revenues. Now health care in San Juan County is the best its ever been (personal communication, 2014).

In 1994, there was evident Navajo community support for school districts to introduce cultural appreciation through "bilingual endorsement classes" such that both student and teacher would be able to understand and appreciate one another. This was misinterpreted by some

[whites] as "getting all the white teachers out of the schools and all the white people who are in business on the reservation off it." (Blue Mountain Panorama, 7/6/1994, page 4). Moreover, the editorial by Doris Valle indicated that Peterson Zah, Navajo Tribal Chairman and Mary Maryboy, San Juan County Commissioner were into nationalism, a "Navajoland for the Navajos" movement. She ended her column by stating, "Prejudice—the reaction toward any person because of his color, race, or religion is bad. Prejudice is spelled H.A.T.E."

The late Cal Black, San Juan County Commission, once barked at a Navajo county resident who came to a commission meeting and asked what services the County was providing to Navajo residents. Mr. Black answered, "We offer many services like road, health, social services. It's your tribal government that isn't helping you" Mr. Black did not elaborate on the specific services provided at that time, especially in health services. (San Juan Record)

Darrell Peck, former mental health counselor in San Juan County: "In the earlier days there was overt racism in the county. I remember hearing one of the staff in the office saying how Navajos were not clean and people wouldn't rent apartments to them. Maybe things have changed now, I hope, but it was bad in those days." (Personal communication April 2015).

Mark Maryboy, former Navajo San Juan County Commissioner, recalled an incident while a student at Bluff Elementary School. "I was playing with a white boy at recess," he recalls. "I saw a little dog and picked it up. I was petting it, and the boy cussed me out and said, 'Don't hurt that puppy, you savage.' " (Christopher Smart, The Salt Lake Tribune, Published March 5, 2006 9:58 am[10]).

In his book about the planning for the new college, McPherson (1997) described the Native American and whites relations in the early 70's as follows: "The population at that time

[10] http://www.sltrib.com/ci_3572258

could be split roughly in half. Native Americans comprised primarily of Navajo residents, lived in the southern third of the county, while the small Ute community of White Mesa sat eleven miles outside of Blanding. The northern two thirds of the county held the white population and most of the schools and business. The San Juan River separated the north from the southern reservation lands in a type of Mason-Dixon line that was as much cultural and social as it was economic and political. Cracks in this caste system, however, started to fracture this long studding division."

In meeting a 2001 Commissioner meeting welcoming the new hospital administrator, John Hart, Mark Maryboy's advice to him was "Keep an open mind, stand on your own, don't judge people based on past situations." (Commission Minutes, 4/16/01).

Donna Singer, who was employed by San Juan Hospital as a radiology technician, had served as an advocate for health care for all San Juan County residents over the years. While she was an employee of the San Juan County Hospital in Monticello, she recounted an incident whereby the Hospital received a Navajo patient from Monument Valley Adventist Hospital (MVAH) who was transported by ambulance and accompanied by a MVAH doctor. The patient was refused admission to the emergency department to have an ultrasound done. The doctor who had accompanied her was not allowed to enter the hospital as he did not have privileges. The patient needed an ultrasound, as MVAH did not have this equipment, for the doctor to determine her condition and whether or not to refer her out. As the radiology technician, Ms. Singer decided to take the ultrasound unit outside of the hospital and to the parking lot where images were taken of the patient in the ambulance. She remarked, "We're all God's children." Singer indicated that this took place shortly before MVAH closed its doors and before she was fired by the hospital (Donna Singer, personal communication 2014; 2015).

On March 1, 2015, San Juan County established its own health department. They hired Donna Singer as a consultant as she knew and is respected by the Navajo communities in the southern portion of the county. She had been instrumental in health care as CEO of UNHS and CEO of BMH until 2014 (BMH 2/13/14). In a public meeting, she remarked that the new health department would serve all the residents of San Juan County. "And that means that the border of San Juan County is Arizona. That means those services belong here [in the south] as well as in Blanding and Monticello." She added, "And we're hoping our focus is to convince everybody that we can all work together and accomplish much more. But in doing that there has to be quality of service south of Blanding. The game's not over." "If we can get everybody together and recognizing that this county goes from the Arizona border to Moab, that we can all work together, we can do so much more for everyone" Singer continued. "There are issues in this community that need to be addressed. Access to water, air quality, these are all things that can come under the department of health with the state and county all working together. There are things we can do to make it better. And if we all work together we can do it" (BMH newsletter, 3/19/14).

In a phone interview with the new health department director, Worthy Glover, Jr. spoke of the need to reach out to the entire San Juan County and importance of coordinating with all providers for public health services (July 2015.)

IV. CONCLUSION

The Navajo people of San Juan County, Utah, endured a tremendous amount of suffering and death from the early days of the 1950's and in later years because of poor health conditions in the population, and due to a lack of adequate organized health and medical care, though some services were offered by religious organizations, the Episcopal mission and the Seventh Day

Adventists. Because Indians were not considered taxpayers or paying patients they were unable to fully use San Juan County Hospital services. Many were referred to Indian Health Service facilities when there were restrictions on contract health care between the Hospital and the IHS. Even laboring women were referred when delivery wasn't eminent. Navajo people traveled long distances throughout the Four Corners to access health care. Many white advocates supported the establishment of medical facilities in Blanding to accommodate Navajo, Ute and white patients.

There was much frustration working against a health care system that was for local whites until about 2000 when local Navajo advocates brought in the Utah Navajo Health System health centers that replaced the old UNDC facilities. And local Navajo, Ute, and white people of San Juan County, together, established the Blue Mountain Hospital for all of San Juan County. In 2015, a new county health department has been established, but there is no indication at this point whether Ute and Navajo citizens will be provided adequate health care services by this organization.

Lillian Tom-Orme

Lillian Tom-Orme

August 27, 2015

Date

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